but not limited to, commencing negotiations with the Government of India to cease the transfer of Advanced Light Helicopters to Burma's military regime; discontinuing all future defense production cooperation with India that might lead to transfers of embargoed controlled equipment to Burma; attaching to all future licenses for transfers of controlled goods and technology to India a strict and enforceable condition, with penalty clauses prohibiting re-export to states under an embargo to which the original exporting state is party without express governmental permission; and drawing attention to the high likelihood of that military equipment being used by Burma's military to commit ethnic cleansing and crimes against humanity in violation of international law including international human rights and humanitarian law.

HONORING ROBERT AYERS GOULD, SR.

HON. JEB HENSARLING

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, August 3, 2007

Mr. HENSARLING. Madam Speaker, today I would like to honor Mr. Robert Ayers Gould, Sr. on the occasion of his retirement after twelve years of service on the City Council of Athens, Texas, where he has overseen many projects benefiting his community.

After graduating from Athens High School in 1957, Robert joined the United States Navy where he served aboard the USS *Coral Sea.* Following an Honorable Discharge, he returned to Athens where he opened the Gould Insurance Agency in 1962, which he has owned and operated for over forty years.

Among his many civic activities, Robert has been the Director and Vice-President of the Athens Chamber of Commerce, Co-Founder of the Texas High School Basketball Hall of Fame, and the Charter Director for the Henderson County YMCA. He has also received many awards from his community including the Roadhand Award from the Texas Highway Commission and the Athens Citizen of the Year Award in 1984.

Robert is married to Mrs. Peggy Lorene Lubben Gould, and they have four children: Robert Jr., Joseph, Patricia, and Mary.

Madam Speaker, as the representative of the City of Athens, Texas, it is my pleasure to congratulate Mr. Robert Ayers Gould, Sr. on his retirement from the City Council.

CHILDREN'S HEALTH AND MEDICARE PROTECTION ACT OF 2007

SPEECH OF

HON. JOHN S. TANNER

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 1, 2007

Mr. TANNER. Mr. Speaker, I rise today with regard to H.R. 3162, The Children's Health and Medicare Protection Act of 2007, and in particular with regard to Section 502, ''Payment Inpatient Rehabilitation Facility (IRF) Services.''

Section 502 takes critically important steps towards ensuring that Medicare beneficiaries have access to medically necessary inpatient rehabilitation in an appropriate treatment setting by permanently extending the 60 percent compliance threshold and by retaining co-morbidities in these provisions. Section 502 prevents further negative impacts from the Centers for Medicare and Medicaid Services' (CMS) 70 Percent Rule policy, which since the Rule's implementation, has deprived more than 100,000 Medicare beneficiaries access to inpatient rehabilitation care despite their meeting medical necessity standards. I strongly support this permanent extension of the 60 percent compliance threshold.

Section 502 also provides for a permanent extension in co-morbidities policy in ascertaining compliance with the rule. An estimated seven percent of the inpatient rehabilitation cases obtain eligibility through co-morbidities. Reversing this policy would adversely impact both beneficiaries and providers. CMS, in promulgating its Final Rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) which will be published in the Federal Register on August 7, 2007, has determined that effective July 1, 2008, co-morbidities may no longer be used to determine whether a provider meets the compliance threshold. The importance of Section 502 is particularly urgent in light of this recent regulatory action.

I urge the House to take a firm stance when conferencing with respect to the inpatient rehabilitation provisions of Section 502. More than half of the House has joined as co-sponsors of H.R. 1459, which I—along with my Colleagues Mr. HULSHOF of Missouri, Mrs. LOWEY of New York, and Mr. LOBIONDO of New Jersey—introduced to ensure that the 60 percent compliance threshold is made permanent and that the co-morbidities provision is extended. I take seriously the trust that has been placed in me by these other 221 House co-sponsors, and I ask that the Conferees do the same.

I also ask that the House safeguard the important provisions of H.R. 3162 that will yield critically important new information and data by requiring the Secretary to report on beneficiaries' access to medically necessary rehabilitative care and variation in that care across treatment settings. The reporting requirements also call for consideration of patients' length of stay and the frequency of readmission in evaluating cost effectiveness for an entire episode of care. These requirements accurately reflect the information necessary for educated decision-making, and we commend their inclusion in Section 502.

There are two issues related to the legislation which I respectfully request our colleagues consider in any future conference negotiations. The House bill currently fails to fix Local Coverage Determinations (LCD) and medical necessity criteria issues which have become apparent in various areas throughout the country. We should not deliver a bill that addresses the compliance threshold but fails to deal with the simultaneous problems apparent in large areas of the country—where Medicare Fiscal Intermediaries are imposing narrow and restrictive interpretations which further limit access to medically necessary rehabilitation care and disregard physician judgments. I appreciate the commitment to addressing these issues demonstrated in Committee. As CMS and its contractors persist in imposing oversight requirements on the inpatient rehabilitation field which are far in excess of those imposed on any other health care sector under Medicare, a more reasonable approach is needed. Congress should codify Ruling 85–2, as called for in H.R. 1459. I appreciate that Chairman STARK has shown his willingness to continue working towards a resolution of our concerns.

In addition, we strongly believe that Section 502 moves in precisely the wrong direction in making radical changes to payment rates for hip and knee replacement and hip fracture cases. We believe neither CMS nor Congress has the clinical data and comparative research necessary either on which to base this policy or to understand the impact of this decision. We should support accurate payments by the Medicare program that are based on sound analysis, clinical evidence, and aligned with the actual cost of providing high quality care. Instead, Section 502 uses the average per-stay skilled nursing facility payment rate as a baseline for calculating repayment in the inpatient rehabilitation context. Inpatient rehabilitation is fundamentally different and clinically more advanced than skilled nursing care. For patients requiring medical rehabilitation, these settings are not interchangeable. Therefore, the payments should not be interchangeable. Paying inpatient rehabilitation providers a lower amount bases on the rate for nursing facilities is contrary to the principles of pay-for-performance.

Finally, we believe that the overall changes in payment rates called for in Section 502 results in a disproportionate financial impact for the rehabilitation hospital sector. Inpatient medical rehabilitation accounts for $6 billion in annual Medicare spending out of a total estimated $437 billion in 2007. Scoring by the Congressional Budget Office (CBO) confirms that payments to the sector will be reduced by $2.4 billion over a 5-year period, and $6.6 billion over 10 years. In other words, inpatient rehabilitation hospital reductions represent 41 percent of Part A spending cuts currently in the bill for a sector that represents a mere 1.4 percent of total Medicare spending. Inflicting 41 percent of the Part A spending cuts on this sector appears to be disproportionate.

In addition, it should be noted that the rehab hospital sector has already absorbed substantial cuts as a result of the phased implementation of the 75 Percent Rule policy. Data from the Centers from Medicare and Medicaid Services (CMS) confirm that rehabilitation providers experienced cuts of at least $300 million in the first year of implementation alone.

The Department of Health and Human Services and CMS initiated the 75 Percent Rule without direction from Congress, and have moved forward with the policy in an unbridled way. It is imperative that this Congress take the necessary steps to protect patient access to inpatient rehabilitation hospital-level services. A final bill must be more reasonable for the rehabilitation sector and fairer to Medicare beneficiaries.

I look forward to continuing to work with my colleagues to retain the 60 percent compliance threshold and co-morbidities and address the remaining problematic issues relating to local coverage determinations and medical necessity criteria, and our payment policies for hip and knee conditions, as the legislative process moves forward.